



**COUNTY OF LOS ANGELES
DEPARTMENT OF AUDITOR-CONTROLLER**

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AUDITOR-CONTROLLER

January 21, 2003

TO: Supervisor Yvonne Brathwaite Burke, Chair
Supervisor Gloria Molina
Supervisor Zev Yaroslavsky
Supervisor Don Knabe
Supervisor Michael D. Antonovich

FROM: J. Tyler McCauley 
Auditor-Controller

SUBJECT: **RANCHO LOS AMIGOS NATIONAL REHABILITATION
CENTER REVIEW**

As directed, we contracted with a consultant to conduct an independent analysis of eight operational models developed by DHS to evaluate whether RLAHRC could operate at a County subsidy of \$14.7 million. The \$14.7 million represents the amount DHS believes it will be able to budgetarily allocate for the services currently provided at the facility. The consultant selected was blueConsulting, Inc.

The consultant concurs with DHS' assessment that none of the models are feasible. An additional five DHS models were also reviewed and found not to be feasible.

As part of their review, the consultants developed a best-case model for RLANRC operating as a "Medical Authority" with a County subsidy of \$14.7 million. This model is also problematic because it would require significant cost reductions, census reductions, legislation changes and changes to agreements with the State and Federal governments regarding SB855 and SB1255 revenues. In addition, because the facility would not have the capacity to service all indigent patients, the County would have to expend an estimated \$10 million for services elsewhere. Also, the County would have to fund \$25 million in allocated fixed costs.

In conjunction with this review, the Auditor-Controller prepared an analysis of net County cost based upon various operating models. The most cost effective model is to close RLAHRC altogether and provide care at the other DHS facilities. Depending on the indigent census, the estimated savings range from \$60.6 million to \$51.6 million. Actual savings could be somewhat less. The calculations assume that Health Services

Administration will reduce costs by \$4.1 million (approximately 40 positions) that could not otherwise be reduced if RLANRC did not close. A reduction plan has not yet been prepared. The calculations also assume rehabilitation care can be provided at the other facilities at their current average variable cost. There would also be some costs associated with closing the facility and start up costs at the other facilities.

We would like to thank blueConsulting, Inc. and DHS staff for their work on this project. If you have any questions regarding this matter, please call me or have your staff call Pat McMahon at (213) 974-0729.

JTM:PTM:mv

c: David E. Janssen, Chief Administrative Officer
Thomas L. Garthwaite, M.D., Director and Chief Medical Officer
Conseulo Diaz, Executive Officer, RLANRC

blue

CONSULTING a clear perspective

January 17, 2003

Mr. Pat McMahon
Assistant Auditor-Controller
County of Los Angeles
500 W. Temple Street
Los Angeles, CA 90012

Dear Mr. McMahon:

blueCONSULTING, INC. is delighted to present this Final Report of the Fiscal and Operational Analysis of the Rancho Los Amigos National Rehabilitation Center (RLANRC). We sincerely appreciate all of the time and cooperation from personnel within the Department of Health Services, RLANRC, the Office of the Auditor-Controller, and other County departments. Working together, I think we have provided a report that will be informative to the Board of Supervisors in their deliberations regarding RLANRC.

If you have any questions regarding our analysis and report, do not hesitate to contact me.

Best regards,



John P. Conley
Managing Director

FINAL REPORT
January 21, 2003

**Fiscal and Operational Analysis
of
Rancho Los Amigos
National Rehabilitation Center**

**Prepared for the
County of Los Angeles
Auditor-Controller**

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**RANCHO LOS AMIGOS NATIONAL REHABILITATION CENTER
FISCAL AND OPERATIONS ANALYSIS**

TABLE OF CONTENTS

EXECUTIVE SUMMARY	1
RLANRC SAVINGS SCENARIOS.....	4
I. OBJECTIVE 1.....	7
II. OBJECTIVE 2	9
III. OBJECTIVE 3.....	12
<i>Exhibit III-I: Scenarios BC-1 and BC-2 Financial Projections.....</i>	<i>13</i>
IV. OBJECTIVE 4	15
V. OBJECTIVE 5.....	18
RLANRC SAVINGS SCENARIOS.....	18
VI. OBJECTIVE 6	21
<i>Exhibit VI-I: Characteristics of Comparable Facilities.....</i>	<i>24</i>

APPENDICES

I-A	Review of Key Assumptions In Planning Model
II-A	Presentation of blueCONSULTING Scenarios
III-A	Brief Discussion of Alternative Models
IV-A	Hospitals With Rehab Beds and Medi-Cal Contracts
IV-B	Survey of Selected Bed Availability and Occupancy
IV-C	List of Referral Hospitals to Rancho
IV-D	Referrals to Other Facilities
IV-E	List of Publications and Background Materials
IV-F	Brief Description of Medicaid Disproportionate Share Hospital (DSH) Program
V-A	Cost to Provide Indigent Care in County and Private Facilities
V-B	Analysis of Ongoing Costs for Rancho Prepared by Auditor-Controller
V-C	Savings Scenarios Prepared by the Auditor-Controller

RANCHO LOS AMIGOS NATIONAL REHABILITATION CENTER FISCAL AND OPERATIONS ANALYSIS

EXECUTIVE SUMMARY

In the Fall of 2002, the Board of Supervisors of Los Angeles County reviewed a series of financial models developed by the Department of Health Services (DHS) and Rancho Los Amigos National Rehabilitation Center (RLANRC) with respect to the cost of operating RLANRC under a variety of what DHS considered to be “best case” scenarios. The purpose of the development of these scenarios was to determine if there was a viable scenario in which RLANRC could be operated at a County financial subsidy limited to \$14.7 million per year.

A total of eight scenarios were presented to the Board. None of the eight scenarios presented met the test of requiring only a \$14.7 million annual subsidy. The Board was also informed that an alternative governance structure for RLANRC could save the County approximately \$64 million in FY 04/05 and \$70 million in FY 05/06. DHS believes that similar savings are possible by closing RLANRC.

Following its examination and analysis of the scenarios presented, the Board voted to instruct the Auditor-Controller to engage an outside consultant to review the DHS financial analyses, and calendar a Beilenson hearing to consider reductions and/or closure of RLANRC.

Subsequent to the Board’s action, the Auditor-Controller for Los Angeles County contracted with blueCONSULTING, INC. (blueCONSULTING) to conduct a study with the following six objectives:

- Objective 1 – Review and validate the financial models developed by DHS to analyze eight different scenarios regarding the operation of RLANRC.
- Objective 2 – Determine if there is any form of operation for RLANRC to operate with a County contribution of \$14.7 million¹. Develop additional scenarios.
- Objective 3 – Determine the minimum County contribution needed to keep RLANRC operating assuring the most efficient operation.
- Objective 4 – Determine the extent that the services provided at RLANRC are available at other non-County facilities. Is there sufficient capacity?
- Objective 5 – Determine the cost to the County to provide services to County-responsible patients at private facilities.
- Objective 6 – Determine whether any similar hospitals exist and the extent to which they are subsidized. Determine significant differences in their operations from RLANRC to identify areas the County can pursue to obtain self-sufficiency.

The results of this study and its attendant analyses led the blueCONSULTING team to the following conclusions.

¹ blueCONSULTING conducted its analysis utilizing the FY 04/05 timeframe for achieving a subsidy level of \$14.7 million.

Objective 1 Conclusion

Although the eight scenarios presented to the Board represent a valid and methodologically sound approach for making accurate financial projections, the scenarios rely on a number of assumptions that we find questionable as to reasonableness and achievability. Therefore, they do not appear to be feasible.

The additional five scenarios developed by RLANRC subsequent to the Board's decision (Numbered 9-13) also contain assumptions that do not appear feasible.

Objective 2 Conclusion

blueCONSULTING, working with the DHS/RLANRC model and staff, developed two new "Medical Authority" scenarios (BC-1 and BC-2) that incorporate changes to some of the financial assumptions that we believed were unrealistic in the prior scenarios. These changes included: decreasing or increasing capacity (BC-1 reduces Average Daily Census (ADC) to 138 from 200; BC-2 increases ADC to 248 from 200); increasing employee benefits costs (from 17% to 30%); changing the variable and fixed cost ratios (to 60/40); restating the baseline level of indigent care at 22% of the total (approximately 30%, identified as Unreimbursed, had been used in prior scenarios), and increasing debt service for Building B (BC-2), among others.

Objective 3 Conclusion

Only one new scenario, BC-1, indicated that it might be possible for RLANRC to operate with a net County contribution close to \$14.7 million in FY 04/05. However, due to the magnitude of the dollars incorporated into the assumptions, and the imprecision inherent in any forecasting effort, we believe that to estimate an exact subsidy amount would imply a level of precision not achievable in this type of exercise.

Scenario BC-1 can only be achieved if RLANRC changes its operating model, aggressively and materially reduces its costs, and reduces services and the number of indigent patients it serves. Whether or not RLANRC can operate with a subsidy of \$14.7 million or less depends largely on achieving requirements that will be very difficult to accomplish by FY 04/05. These include:

- Ability to gain the County and State legislative and executive support necessary to transform its operational model into a "Medical Authority," which would operate as a Quasi-Governmental Organization (QGO) in a timely manner. This would potentially include securing changes in agreements between the Federal and State government and the State and County government with respect to SB 855 and SB 1255 and the attendant Inter-Governmental Transfers (IGT).
- Preserve RLANRC's status as an acute inpatient hospital and maintain operating room capacity in the existing facility as long as possible.
- Secure revenue rates and allocations comparable to present rates and allocations, including the level of SB 855, SB 1255, and SB 1732 funding.

- Significantly transform its operating cost structure. To transform its cost structure, RLANRC will likely need considerable support and concessions from Labor, and RLANRC's management must aggressively develop and adopt a transformation plan that includes material changes in levels of services and associated costs.

The calculation of the minimum County contribution needed depends on the achievability of revenue and cost assumptions. The newly developed scenario (BC-1) indicates that it is potentially possible to operate RLANRC near the \$14.7 million County contribution level. In BC-1, services to indigent patients would be potentially shifted to other county facilities because the scenario calls for a reduced indigent patient load at Rancho. These costs for the patients shifted to other facilities are estimated at approximately \$10 million. However, to the extent RLANRC's indigent patients are served by other remaining DHS facilities, some program and service adjustments would likely be needed. Therefore, the net increased cost of indigent care at other DHS hospitals would only occur if resources are increased at receiving hospitals. It is our understanding that it is the County's intent not to increase resources at receiving hospitals, but will prioritize care based on appropriate medical standards. It is also important to note that, even in BC-1, a substantial portion of RLANRC's costs are fixed costs, and that some would remain largely the same to the County.

Additionally, there are approximately \$14 million (BC-1) to \$20 million (BC-2) of combined SB 855 and SB 1255 revenue included in these scenarios. As a separate Medical Authority, RLANRC may not qualify for a substantial portion of these revenues without legislative changes and/or changes in agreements between the State and County with respect to these programs. Continuation or replacement of these revenues is a critical assumption in the achievability of these scenarios.

Both Scenarios BC-1 and BC-2 assume RLANRC is a going concern, using a Medical Authority model. However, these require substantial and aggressive operational changes and cost reductions. DHS' and RLANRC's ability to make such significant changes in their operations over a relatively short period of time may or may not be achievable, and poses a potentially substantial risk to the County.

Objective 4 Conclusion

Patients with acute medical or surgical diagnoses who are currently treated at RLANRC could be treated in the larger health care community of Los Angeles, assuming the County provides an adequate level of reimbursement for the indigent and uninsured patients who are its responsibility. There are also a sufficient number of licensed rehabilitation and acute inpatient beds at non-County facilities to serve RLANRC's rehabilitation patients².

However, hospitals in the community do not currently have adequate staff available to provide the same amount and type of coordinated, high-level service that rehabilitation patients currently receive at RLANRC due to budget constraints and the reported shortage of nurses and therapists (Physical Therapy, Occupational Therapy, Speech Therapy).

² Based upon DHS bed license statistics and a sampling of hospitals.

There may be significant variation in area hospitals' willingness to accept the patients currently cared for at RLANRC, depending upon acuity and payer type. No private facility contacted expressed an interest in absorbing County indigent patients unless an acceptable rate of reimbursement was provided³ nor are there any incentives for non-County facilities to take RLANRC's high-acuity, resource-intensive patients when their facility can maintain high occupancy rates with lower acuity patients.

Objective 5 Conclusion

blueCONSULTING computed the cost to the County to provide indigent care in private facilities using market rates. For purposes of this report, we have used RLANRC's Unreimbursed patient load, comprised of County residents under 200% of the Federal poverty level. This definition could include more patients than the County is obligated to provide services to, pursuant to WIC Section 17000. We also estimated the cost to provide indigent care in other County facilities using a weighted average of their variable costs. These computations indicate that the care would cost about \$25 to \$37 million in private facilities and \$19 to \$28 million in County facilities, based on an estimation of indigent days/visits ranging from 20% to 30% of RLANRC's total days.

RLANRC SAVINGS SCENARIOS

An Auditor-Controller's review of projected savings indicated that savings resulting from various RLANRC scenarios are not automatic and are contingent upon several assumptions. The first is that there will be an approximately \$4.1 million reduction in Health Services Administration (HSA) that would not have occurred if RLANRC were not closed. This equates to approximately 40 positions attributable to RLANRC. DHS has not yet identified the positions or other cost reductions attributable to the closure of RLANRC.

DHS projected savings also assume that the other DHS facilities will receive \$36.6 million in reallocated revenue. DHS indicated that, if RLANRC closes, they believe the County will reallocate \$36.6 million from SB 1255 and other revenue to other County facilities. The last assumption in the DHS closure savings analysis is that services to indigent patients currently treated at RLANRC can be reduced and provided at other DHS facilities at no additional cost. DHS indicated that it is the County's intent not to increase resources at receiving hospitals, but will prioritize care based on appropriate medical standards.

As previously indicated, DHS' position is that it will only spend \$14.7 million on indigent care. Because of the uncertainties regarding what actually would happen in the event RLANRC closes or becomes an authority, the Auditor-Controller has prepared ten scenarios of the County savings under various assumptions. The potential savings range from \$64.9 to \$21.7 million.

³ While there was no attempt to determine precisely what an "acceptable rate" would be as part of this project, for purposes of estimating costs to county, market rates were utilized for placement in private facilities.

⁴ Based upon DHS bed license statistics and a sampling of hospitals.

Savings Scenarios

1. Assumes RLANRC closes altogether and that the cost of indigent care will be DHS' proposed funding of \$14.7 million. Savings of \$64.9 million.
2. Assumes RLANRC closes altogether and that the variable cost of providing indigent care at other DHS facilities assuming a 20% indigent rate is \$19 million. Savings of \$60.6 million.
3. Assumes RLANRC closes altogether and that the variable cost of providing indigent care at other DHS facilities assuming a 30% indigent rate is \$28 million. Savings of \$51.6 million.
4. Assumes RLANRC closes altogether and that the County cost of obtaining indigent care at private facilities assuming a 20% indigent rate is \$25 million. Savings of \$54.6 million.
5. Assumes RLANRC closes altogether and that the County cost of obtaining indigent care at private facilities assuming a 30% indigent rate is \$37 million. Savings of \$42.6 million.
6. Assumes RLANRC becomes a medical authority and the County cost of indigent care will be DHS' proposed funding of \$14.7 million. Savings of \$44 million.
7. Assumes RLANRC becomes a medical authority and the County variable cost of providing indigent care at other DHS facilities assuming a 20% indigent rate is \$19 million. Savings of \$39.7 million.
8. Assumes RLANRC becomes a medical authority and the County variable cost of providing indigent care at other DHS facilities assuming a 30% indigent rate is \$28 million. Savings of \$30.7 million.
9. Assumes RLANRC becomes a medical authority and that the County cost of obtaining indigent care at private facilities assuming a 20% indigent rate is \$25 million. Savings of \$33.7 million.
10. Assumes RLANRC becomes a medical authority and that the County cost of obtaining indigent care at private facilities assuming a 30% indigent rate is \$37 million. Savings of \$21.7 million.

DHS' and RLANRC's ability to reduce costs and make significant changes in their operations over a relatively short period of time – and absorb indigent patients at no additional costs at other County facilities – may or may not be achievable, and poses a potentially substantial risk to the County.

Objective 6 Conclusion

There are numerous rehabilitation facilities around the nation, a number of which offer services commensurate with those provided at RLANRC. However, there do not appear to be any rehabilitation facilities of the caliber of RLANRC⁵ that are similar in terms of governance and low-income utilization levels. Accordingly, RLANRC is a unique facility offering a high level of rehabilitation services to a multicultural patient base, while operating as a public hospital. However, even despite RLANRC's unique status as a public hospital, there are a few insights into self-sufficiency that can be drawn from comparisons with other "top tier"⁶ rehabilitation facilities around the country.

Self-sufficiency in an environment characterized by relatively restricted reimbursement levels (high Medicaid and indigent care caseloads) is inevitably tied to an organization's ability to tightly manage major cost components within the facility, such as labor and capital improvements. Both will be difficult for RLANRC in the coming years given the seismic upgrades required to maintain a facility of its current size and the costs associated with the County's labor structure.

The remainder of this report discusses each of the six objectives of the study. For each objective a summary analysis is provided, followed by the methodology used to analyze the issues and costs associated with the objective and, the findings and conclusions that are drawn from those analyses.

⁵ Based on the *US News & World Report* survey.

⁶ As identified in the *US News & World Report* survey.

I. OBJECTIVE 1

Objective 1: *Review and validate the financial models developed by DHS to analyze eight different scenarios regarding the operation of RLANRC*

Summary Analysis

Our review indicates that although the models represent a valid and methodologically sound approach for making accurate financial projections, the scenarios developed using the models rely on a number of assumptions that we find questionable as to reasonableness and achievability.

The staff at DHS and RLANRC have developed useful financial modeling tools and used them to project RLANRC costs, revenues and other financial variables to the year FY 04/05 under a range of assumptions. By applying the models and varying the assumptions, DHS and RLANRC developed eight scenarios. Later, RLANRC added five more scenarios for a total of thirteen. Decisions regarding which assumptions to use in developing the scenarios were left primarily to RLANRC financial staff with little, if any, clinical input even though a number of the assumptions would substantially change RLANRC's future medical services and patient case mix. At our request, RLANRC management, including the medical staff, reviewed the thirteen scenarios and chose Scenarios 9 and 10 as their favored approaches. Our analysis of the key assumptions used in the scenarios, highlighting Scenarios 9 and 10, is presented in detail in Appendix I-A where we provide our assessment of each assumption.

Methodology

To accomplish Objective 1, the blueCONSULTING team:

- Reviewed the logic and methodology employed in the models to make projections of cost, revenue and other financial variables.
- Analyzed the supporting rationale for the model's assumptions under each scenario.
- Validated selected model computations and supplemented our review with validation work by the County Auditor Controller's office.
- Assessed reasonableness and achievability of scenario assumptions based on blueCONSULTING team assessment.

Findings and Conclusions

- The financial model uses a valid and methodologically sound approach to projecting RLANRC costs, revenues and other financial variables, but some of the assumptions used in developing Scenarios 1 through 13 are questionable as to their reasonableness and achievability.
- The model's financial projections can vary substantially with changes in the assumptions used in the scenarios; additionally, a one-year projection (04/05) time frame was utilized based on timing constraints and on preliminary instructions from the County. Typically, a longer projection period (3 to 5 years) would be utilized.

- We reviewed the assumptions in each of the DHS/RLANRC scenarios (1 through 13). Among the many assumptions utilized, blueCONSULTING found the following assumptions to be the most questionable in terms of realistic achievement in the time frame given (FY 04/05).
 - Rancho will be established as a “Medical Authority,” as a Quasi-Governmental Organization (QGO).
 - Legislative action, at the state and local level, will be favorable and timely. Noteworthy are: establishment of the QGO, continued participation in or replacements for SB 855 and SB 1255 revenue allocations, continued participation in SB 1732 privileges, continuation of IGT status and current DSH allocation.
 - The new Authority/QGO will operate RLANRC with its current licenses and will have reimbursement rates equal to its current CMAC rates.
 - The unions and/or future employees will accept significantly different work terms, including staffing models that adjust to meet workloads, reduced compensation levels and employee benefits, etc.
 - Expenses could be substantially reduced. Revenues and expenses were underestimated in all 13 scenarios. The most material understatements were in the areas of employee benefits. Scenarios 1-13 reflect only a 17% employee benefits burden rate.
 - Services and payment sources could be “re-mixed.” Some scenarios “re-mixed” services and payers from low margin to high margin without any articulated clinical or marketing impact assessments.
 - Some patients previously considered to be the responsibility of the County were simply not going to be served at RLANRC.
- blueCONSULTING Team's assessment of each assumption is listed in Appendix I-A.

II. OBJECTIVE 2

Objective 2: Determine if there is any form of operation for RLANRC to operate with a County contribution of \$14.7 million. Develop additional scenarios.

Summary Analysis

blueCONSULTING, working with the DHS/RLANRC model and staff, developed two new “Medical Authority” scenarios (BC-1 and BC-2) that incorporate changes to some of the financial assumptions that we believed were unrealistic in the prior scenarios (see Appendix II-A). Only one of these new scenarios, BC-1, indicated that it might be possible for Rancho to operate with a net County contribution close to \$14.7 million in FY 04/05.

The difference between Scenarios BC-1 and BC-2 is that BC-1 assumes that RLANRC operates in its current facilities as long as possible, although with a reduced Average Daily Census (ADC). Because Scenario BC-1 does not include new construction at the RLANRC facility, it does not address the longer term issues associated with seismic retrofitting of the existing building that includes Rancho’s operating rooms. Accordingly, if RLANRC is to continue to be classified as an acute inpatient hospital, operating room capacity will ultimately have to be added to the Jacqueline Perry Institute (by 2008), when the older building must be retrofitted or abandoned. It further assumes that RLANRC continues to use the operating rooms in the non-seismic compliant building in the near term. This scenario also assumes that RLANRC reduces its ADC from its current level of about 200 patients to about 138, by limiting its inpatient bed capacity to the 150 beds in the Perry Institute.

Under Scenario BC-2, developed at the request of Rancho and DHS, we assume Building B, a new inpatient building that we have been advised has been under discussion for many years (and is assumed to be built under all 13 DHS/RLANRC scenarios), is constructed. The addition of Building B could allow the RLANRC ADC to rise to about 248. It is important to note that Building B could not be built within the FY 04/05 time horizon for this study, and that services would need to be provided in current buildings in the interim.

Again, whether or not RLANRC can operate with a subsidy of \$14.7 million or less under scenario BC-1 depends largely on achieving requirements that are very difficult to accomplish by FY 04/05, including:

- Ability to gain the County and State legislative and executive support necessary to transform its operational model into an “Medical Authority” (QGO) in a timely manner. This would potentially include securing changes in agreements between the Federal and State government, and the State and County with respect to SB 855 and SB 1255 and the attendant intergovernmental transfers;
- Preserve RLANRC’s status as an acute inpatient hospital and maintain operating room capacity in the existing facility as long as possible;

- Secure revenue rates and allocations comparable to present rates and allocations. This would require no change in CMAC rates or the level of SB 855, SB 1255 and SB 1732 funding. (The total of SB 855 and SB 1255 revenue is approximately \$14 million in BC-1 and \$20 million in BC-2.)
- Significantly transform its operating cost structure. To transform its cost structure, RLANRC will likely need considerable support and concessions from Labor, and RLANRC's management must aggressively develop and adopt a transformation plan that includes material changes in levels of services and associated costs.
- Downsize RLANRC to 150 beds and make corresponding reductions in variable costs.
- Maintain operating room capacity and a classification of its inpatient days as acute.

RLANRC's ability to make such significant changes in their operations over a relatively short period of time poses a potentially substantial risk to the County.

Methodology

To accomplish Objective 2, the blueCONSULTING team:

- Analyzed the assumptions used in DHS/RLANRC Scenarios 9 through 13, particularly emphasizing Scenarios 9 and 10 – those chosen by RLANRC management as most achievable;
- Developed two new scenarios: BC-1 (downsized facility with different service mix and an ADC of 138) and BC-2 (increased inpatient capacity with current service mix and an ADC of 248);
- Developed new sets of assumptions for scenarios BC-1 and BC-2 and reviewed them with RLANRC financial staff, who processed them through the DHS/RLANRC model.

Findings and Conclusions

- There are many Scenarios under which RLANRC can *theoretically* operate with a County contribution of \$14.7 million. RLANRC and DHS have produced Scenarios 9 through 13 which meet this contribution limit;
- As indicated under Objective 1, we question certain assumptions used by DHS and RLANRC in developing Scenarios 1 through 13 and we therefore believe that the reasonableness and achievability of these scenarios is questionable;
- Scenarios 9 through 13 were all calculated based on an "Medical Authority" concept and are subject to the same issues and risks noted in Objective 1.
- Additionally, some scenarios within 9 through 13 remain within the proposed County contribution limit by restricting the amount of indigent patient care provided at RLANRC and thereby potentially shifting those costs to other County facilities;
- Indigent patients as classified in Scenarios 1 through 13 as those patients with no source of payment for the care they receive;
- At the time the original scenarios were created, RLANRC's inpatient and outpatient workloads included about 30% Unreimbursed patients (21,874 out of 72,647 days and 17,337 out of 58,848 visits);

- By comparison, Scenarios 9 through 13 assumed only approximately 13% of inpatient days at RLANRC (9,344 days) are attributed to unfunded patients. No explanation was given as to where the patients previously treated at RLANRC as unfunded patients would be cared for. Also, the scenarios assumed that no indigent outpatient visits are provided at RLANRC. Days/visits in highest margin services, on the other hand, are in some cases doubled.
- The blueCONSULTING team developed two new scenarios, BC-1 and BC-2, using the DHS/RLANRC model and using assumptions that incorporate changes to some of the financial assumptions that we believed were unrealistic in the prior scenarios. See Appendix II-A.
- Only under one of these scenarios (BC -1) might the County come close to achieving its goal of limiting its contribution to \$14.7 million. This scenario (BC-1), could only be achieved under a more carefully defined set of assumptions using a Medical Authority concept, with a different mix of services, where RLANRC is downsized to an ADC of 138 and continues to use the operating rooms in its existing facility as long as possible.
- Scenario BC-2 could not likely be implemented, per se, by FY 04/05. In addition to requiring all of the structural and operational changes implied in becoming a Medical Authority, BC-2 assumes the construction of Building B, which could not be accomplished by FY 04/05.

III. OBJECTIVE 3

Objective 3: *Determine the Minimum County Contribution Needed to Keep RLANRC Operating Assuring the Most Efficient Operation.*

Summary Analysis

As discussed in Objective 2, blueCONSULTING developed two sets of alternative scenarios that incorporate changes to some of the financial assumptions that we believed were unrealistic in the original eight and additional five scenarios. The new scenarios require highly-efficient operations of RLANRC as a Medical Authority/QGO. They incorporate assumptions for reduced services and capacity (BC-1) and, alternatively, expanded capacity with the construction of Building B (BC-2).

The calculation of the minimum County contribution needed depends on the achievability of revenue and cost assumptions in the models. The scenarios indicate that it is potentially possible to operate RLANRC near the \$14.7 million County contribution level. However, in BC-1, services to indigent patients would be potentially shifted to other County facilities because this scenario calls for a reduced patient load at Rancho. The costs for the services provided to the displaced patients are estimated at approximately \$10 million. Additionally, there are approximately \$14 million (BC-1) to \$20 million (BC-2) of combined SB 855 and SB 1255 revenue included in these scenarios. As a separate Medical Authority, RLANRC may not qualify for a substantial portion of these revenues without legislative changes and/or changes in agreements between the Federal government and the State and the State and the County with respect to these programs. Continuation or replacement of these revenues is a critical assumption in the achievability of these scenarios. RLANRC's ability to make such significant changes in their operations over a relatively short period of time poses a potentially substantial risk to the County.

The difference between Scenarios BC-1 and BC-2 is that BC-1 assumes that RLANRC operates in its current facilities as long as possible, although with a reduced ADC. Since BC-1 does not include new construction at the facility, it does not address the longer term issues associated with seismic retrofitting in the existing building that includes Rancho's operating rooms. Accordingly, if RLANRC is to continue to be classified as an acute inpatient hospital, operating room capacity will have to be ultimately added to the Jacqueline Perry Institute (by 2008), when the older building must be retrofitted or abandoned. Scenario BC-2 assumes that Building B is constructed and fully utilized for patient care. Building B is a proposed hospital inpatient building that we have been advised has been considered for construction at RLANRC for many years. It is also assumed to be constructed in all 13 scenarios developed by DHS/RLANRC. Its cost in the models is estimated at approximately \$200 million and its construction would allow RLANRC to replace certain existing inpatient buildings that do not currently meet seismic requirements.

In these two scenarios, RLANRC would be handling different indigent patient workloads under each scenario. Alternatives for handling this indigent care need are discussed under Objective 4 and the cost to the County to provide these services to County responsible patients is discussed under Objective 5.

The financial projections and workload assumptions for the two scenarios are shown in the table on the following page.

Due to the order of magnitude of the dollars incorporated in the assumptions, and due to the imprecision inherent in any forecasting effort, we believed that to estimate an exact amount of County subsidy would imply a level of precision not achievable in this type of exercise and within this time frame.

Methodology

To accomplish Objective 3, blueCONSULTING:

- Worked with RLANRC financial staff to incorporate changes to some of the financial assumptions that we believed were unrealistic in the prior scenarios.
- Analyzed and summarized results of scenarios.

Exhibit III-I: Scenarios BC-1 and BC-2 Financial Projections

Financial Projections	Scenario BC-1 (no Building B) (in millions)	Scenario BC-2 (with Bldg B) (in millions)
Revenue	\$85.9	\$130.2
Expenses	<u>85.3</u>	<u>124.3</u>
Potential (deficit) or surplus to Rancho	0.6	5.9
Proposed Gross County contribution to Rancho	14.7	14.7
Net County contribution to Rancho	14.7 (assume minimum fixed contribution)	14.7 (assume minimum fixed contribution)
County Costs (reduction) for indigent patients from/to other County facilities	Discussed in Objective 5	Discussed in Objective 5
Inpatient Information		
Rancho ADC	138	248
Rancho Indigent Inpatient days based on these scenarios ⁷	12,988 @ 30% 10,076 @ 20%	27,256 @ 30% 18,104 @ 20%
Approximate Percentage of Rehabilitation Indigent Inpatients	64 %	42 %

⁷ Historically, 30% of patients treated were Unreimbursed and classified as “indigent.” Since this number fluctuates, a range of 20-30% inpatients classified as indigent has been utilized in this report.

Findings and Conclusions

- The assumptions used in Scenarios BC-1 and BC-2 lead to financial projections that we believe reflect more efficient operations of RLANRC, although not necessarily in FY 04/05 (BC-2), per se.
- The key assumptions incorporated in the two new scenarios are as follows:
 - RLANRC is allowed to operate under a Medical Authority which is established as a Quasi-Governmental Organization. (This review focused only on a Medical Authority model. For information purposes, Appendix III-A provides a brief discussion of a Foundation model and a Satellite model.);
 - RLANRC's status as a Medical Authority will permit it to be classified as a public facility for purposes of receiving SB 855 funding.
 - As a Medical Authority, RLANRC takes aggressive action to make many of the same cost reductions assumed by RLANRC and DHS under their 13 scenarios, and that they will achieve a conservative 60/40 ratio of variable to fixed costs (verses their current reported ratio of 47/53). The 60/40 ratio is closer to other County and non-County hospitals;
 - Employee benefit cuts assumed in the DHS/RLANRC model are added back to RLANRC costs to reflect a 30% employee benefits burden, rather than the 17% in the original scenarios;
 - Debt burden needed to finance construction of Building B is adjusted to a higher level than allowed by the DHS/RLANRC model to reflect increased debt load from constructing Building B;
 - CMAC rates remain stable; and
 - The historical payer mix and case mix remain the same.
- If Building B is constructed as assumed in BC-2, it would supplement the existing 5-year old 150-bed Building A (Jacqueline Perry Institute) which currently meets seismic requirements. With Building B, the ADC at RLANRC was assumed to increase to 248.
- With only the existing buildings, the inpatient average daily census (ADC) was assumed to drop from its current level of about 200 to 138.

IV. OBJECTIVE 4

Objective 4. Determine the extent that the services provided at Rancho are available at other non-County facilities. Is there sufficient capacity?

Summary Analysis

Patients with acute medical or surgical diagnoses who are currently treated at RLANRC could be treated in the larger health care community of Los Angeles, assuming the County provides an adequate level of reimbursement for the indigent and uninsured patients that are its responsibility. There are also a sufficient number of licensed rehabilitation and acute inpatient beds at non-County facilities to serve RLANRC's rehabilitation patients⁸.

However, hospitals in the community do not currently have adequate staff available to provide the same amount and type of coordinated, high-level service that rehabilitation patients currently receive at RLANRC due to budget constraints and the reported shortage of nurses and therapists (Physical Therapy, Occupational Therapy, Speech Therapy).

There may be significant variation in area hospitals' willingness to accept the patients currently cared for at RLANRC, depending upon acuity and payer type. No private facility contacted expressed an interest in absorbing County indigent patients unless an acceptable rate of reimbursement was provided⁹ nor are there any incentives for non-County facilities to take RLANRC's high-acuity, resource-intensive patients when their facility can maintain high occupancy rates with lower acuity patients.

Methodology

To accomplish Objective 4, blueCONSULTING:

- Contacted DHS's Facilities Licensing Division in Los Angeles to obtain an up-to-date, comprehensive list of all facilities in Los Angeles County with rehabilitation beds on their general acute care inpatient license.
- Contacted the California MediCal Assistance Commission (CMAC) in Sacramento to confirm which of the hospitals with rehabilitation beds currently hold MediCal contracts and therefore could accept MediCal (Medicaid) patients if staffed beds were available (see Appendix IV-A). Bed and service data were obtained and cross-referenced the accuracy from the 2002-2003 American Hospital Association Guide (AHA Guide) and the 2002 Membership Directory of the California Healthcare Association of Southern California/Healthcare Association of San Diego and Imperial Counties (CHA Membership Directory).

⁸ Based upon DHS bed license statistics and a sampling of hospitals.

⁹ While there was no attempt to determine precisely what an "acceptable rate" would be as part of this project, for purposes of estimating costs to county, market rates were utilized for placement in private facilities.

¹⁰ Based upon DHS bed license statistics and a sampling of hospitals.

- Contacted those hospitals with the largest rehabilitation bed complements or the greatest rehabilitation expertise to test the level of receptivity of absorbing additional patients (see Appendix IV-B).
- Developed a list of County and non-County hospitals that refer patients to RLANRC. Currently most referrals into RLANRC are from County hospitals, while most referrals out of RLANRC are to sub-acute/SNF facilities, or to home, since rehabilitation is provided (see Appendix IV-C).
- Requested an assessment from the clinical leadership at RLANRC of all patient categories (by clinical classification) to identify the level of facility by bed type that would be required if no service at the current levels were available (see Appendix IV-D).
- Conducted a number of interviews in addition to information gathered for Appendix IV-B (in person and by telephone) to seek informed opinions on the role of rehabilitation in this marketplace, and the potential impact of RLANRC's closure on area providers, including both County and non-County facilities. (It should be noted that the National Health Foundation is currently conducting a comprehensive research study modeling public and private hospitals, emergency departments, and clinic capacity; potential delays; and patient queuing. As the study is in progress, no conclusions have been finalized.)
- Interviewed members of the clinical, executive, financial, and managed care/contracting leadership team of RLANRC to learn as much as possible about the patient population at RLANRC and the type of care that patients would require if RLANRC's services were not available.
- Reviewed a comprehensive list of publications and background materials (see Appendix IV-E) to understand the role of rehabilitation as it applies to the patient population of Los Angeles County and RLANRC's relationship to County and non-County providers.
- Obtained specific information about acuity and resource use in rehabilitation patients. (Reader is referred to *Federal Register, Volume 66, Number 152, 8/7/01, HHS PPS for Inpatient Rehabilitation Services 41316-4143064*. This document explains resource use and payment by acuity for Inpatient Rehabilitation using case-mix index.)

Findings and Conclusions

- There are an adequate number of licensed beds in the greater Los Angeles hospital community, although many hospitals have small rehabilitation bed complements that are occupied at levels of 80% or greater, or specialize in only one type of rehabilitation (e.g., neuro rehab/stroke). However, hospitals in the community do not currently have adequate staff available to provide the same amount and type of coordinated, high-level service that rehabilitation patients currently receive at RLANRC due to budget constraints and the reported shortage of nurses and therapists (Physical Therapy, Occupational Therapy, Speech Therapy).

- RLANRC reports that many of their patients have special language, social, transportation, and family needs that may present issues for those hospitals with sufficient bed capacity but without adequate staff to address these special needs. While those facilities can presumably provide adequate rehabilitation care (comparable to other community providers), they may not be able to provide all of the care coordination and support services available at RLANRC.
- There may be significant variation in area hospitals' willingness to accept the patients currently cared for at RLANRC, depending upon acuity and payer type. No private facility contacted expressed an interest in absorbing County indigent patients unless an acceptable rate of reimbursement was provided¹¹ nor are there any incentives for non-County facilities to take RLANRC's high-acuity, resource-intensive patients when their facility can maintain high occupancy rates with lower acuity patients. Therefore, even higher reimbursement rates may be required to incent these facilities to serve the high-acuity patient population (e.g. respiratory-dependent, adult brain injury, etc.).
- Because there is documented variation of resource use depending upon patient acuity, the actual disposition of patients may vary, with non-County facilities only being willing to absorb some MediCal and lower acuity, non-indigent patients. MediCal rehabilitation patients may be more attractive to those hospitals receiving Disproportionate Share Hospital (DSH) payments (see Appendix IV-F for discussion of DSH payments). County facilities would likely need to absorb the remainder of the patients. This could represent a relatively large increase in patient days for these hospitals.
- No private facility has been identified to take adult or pediatric respiratory-dependent quadriplegic patients, regardless of payer type. It is not clear where this population will go. This population includes 69 adult patients per year with an average length of stay (ALOS) of 84 days, and eight pediatric patients with an ALOS of 90 days, for a total of 6,520 patient days annually.
- There may be increased pressure on emergency departments when RLANRC clinic resources for the indigent are lost. Since 70 to 77% (for FY 01/02 and FY 00/01 respectively) of all current patient referrals into RLANRC come from County hospitals and clinics, the practical impact will be less significant for non-County facilities than for County hospitals, and their emergency departments and clinics.

¹¹ While there was no attempt to determine precisely what an "acceptable rate" would be as part of this project, for purposes of estimating costs to county, market rates were utilized for placement in private facilities.

V. OBJECTIVE 5

Objective 5: Determine the Cost to the County to Provide Services to County Responsible Patients at Private Facilities

Summary Analysis:

We computed the cost to the County to provide indigent care in private facilities using market rates. For purposes of this report, we have used RLANRC's Unreimbursed patient load, comprised of County residents under 200% of the Federal poverty level. This definition could include more patients than the County is obligated to provide services to, pursuant to WIC Section 17000. We also estimated the cost to provide indigent care in other County facilities using a weighted average of their variable costs. These computations indicate that the care would cost about \$25 to \$37 million in private facilities and \$19 to \$28 million in County facilities, based on an estimation of indigent days/visits ranging from 20% to 30% of RLANRC's totals. See Appendix V-A.

Additionally, it is important to note that a substantial portion of the costs to keep RLANRC in operation are fixed costs that would remain largely the same even if RLANRC were to close, remain open and/or become a Medical Authority. Correspondingly, there are fixed revenues which continue even if RLANRC were to close.

Using the analysis prepared by DHS and reviewed by blueCONSULTING, the revenue to the County that would continue irrespective of the closing of RLANRC is estimated at \$35.7 million. The major component of this revenue (\$22 million) is SB 1255 revenue, which is allocated to RLANRC from a fixed sum negotiated by the County and CMAC, and which is allocated to County providers "at the sole discretion" of the County. (See Appendix V-B).

Using an analysis prepared by DHS and reviewed by the County Auditor Controller's Office (Appendix V-B), fixed costs were budgeted to be about \$39.7 million in FY 04/05, including \$4.1 million of internal DHS costs, which DHS committed to reduce if RLANRC closes.

RLANRC SAVINGS SCENARIOS

An Auditor-Controller's review of projected savings indicated that the savings resulting from various RLANRC scenarios are not automatic and are contingent upon several assumptions. The first is that there will be an approximately \$4.1 million reduction in Health Services Administration (HSA) that would not have occurred if RLANRC were not closed. This equates to approximately 40 positions attributable to RLANRC. DHS has not yet identified the positions or other cost reductions attributable to the closure of RLANRC.

DHS projected savings also assume that the other DHS facilities will receive \$36.6 million in reallocated revenue. DHS indicated that, if RLANRC closes, they believe the County will reallocate \$36.6 million from SB 1255 and other revenue to other County facilities. The last

assumption in the DHS closure savings analysis is that services to indigent patients currently treated at RLANRC can be reduced and provided at other DHS facilities at no additional cost. DHS indicated that it is the County's intent not to increase resources at receiving hospitals, but will prioritize care based on appropriate medical standards.

As previously indicated, DHS' position is that it will only spend \$14.7 million on indigent care. Because of the uncertainties regarding what actually would happen in the event RLANRC closes or became an authority, the Auditor-Controller has prepared ten scenarios of the County savings under various assumptions (Appendix V-C). The potential savings range from \$64.9 million to \$21.7 million.

Savings Scenarios

1. Assumes RLANRC closes altogether and that the cost of indigent care will be DHS' proposed funding of \$14.7 million. Savings of \$64.9 million.
2. Assumes RLANRC closes altogether and that the variable cost of providing indigent care at other DHS facilities assuming a 20% indigent rate is \$19 million. Savings of \$60.6 million.
3. Assumes RLANRC closes altogether and that the variable cost of providing indigent care at other DHS facilities assuming a 30% indigent rate is \$28 million. Savings of \$51.6 million.
4. Assumes RLANRC closes altogether and that the County cost of obtaining indigent care at private facilities assuming a 20% indigent rate is \$25 million. Savings of \$54.6 million.
5. Assumes RLANRC closes altogether and that the County cost of obtaining indigent care at private facilities assuming a 30% indigent rate is \$37 million. Savings of \$42.6 million.
6. Assumes RLANRC becomes a medical authority and the County cost of indigent care will be DHS' proposed funding of \$14.7 million. Savings of \$44 million.
7. Assumes RLANRC becomes a medical authority and the County variable cost of providing indigent care at other DHS facilities assuming a 20% indigent rate is \$19 million. Savings of \$39.7 million.
8. Assumes RLANRC becomes a medical authority and the County variable cost of providing indigent care at other DHS facilities assuming a 30% indigent rate is \$28 million. Savings of \$30.7 million.
9. Assumes RLANRC becomes a medical authority and that the County cost of obtaining indigent care at private facilities assuming a 20% indigent rate is \$25 million. Savings of \$33.7 million.

10. Assumes RLANRC becomes a medical authority and that the County cost of obtaining indigent care at private facilities assuming a 30% indigent rate is \$37 million. Savings of \$21.7 million.

Details of these Savings Scenarios are contained in Appendix V-C.

DHS' and RLANRC's ability to make such significant changes in their operations over a relatively short period of time, and absorb indigent patients at no additional costs at other County facilities may or may not be achievable, and poses a potentially substantial risk to the County.

Methodology

To accomplish this objective, the blueCONSULTING team:

- Utilized local market rates based on blueCONSULTING team fact finding.
- Analyzed indigent inpatient and outpatient care projections for FY 04/05 under various scenario assumptions;
- Calculated a range of indigent patient care from 20% to 30% of RLANRC's total days/visits.
- Reviewed both the DHS and the Auditor-Controller's Office analyses of ongoing fixed costs and the major components of DHS' fixed revenue calculations (Appendix V-B).
- Calculated the costs of indigent care within the specified ranges based on market and County rates. (Inpatient indigent costs in private facilities were based on market rates. Inpatient indigent costs in County facilities were based on a weighted average of County facility variable cost, derived from information provided by DHS). Outpatient indigent care rates were estimated based on market estimates derived by blueCONSULTING team fact finding.

Findings and Conclusions

- In FY 00/01, RLANRC's indigent patients incurred 21,873 days of inpatient care (approximately 30% of total days) and 17,335 outpatient visits (approximately 29% of total visits) .
- Based on an estimation of indigent days/visits ranging from 20% to 30% of RLANRC's baseline totals, this care would cost about \$25 to \$37 million in private facilities and \$19 to \$28 million in County facilities.
- Based on an analysis prepared by DHS and reviewed by the County Auditor Controller's Office (Appendix V-B), we estimate that the County fixed expenses were budgeted to be about \$35.7 million in FY 04/05. Additionally, DHS committed to reduce its internal costs by \$4.1 million.
- Using the analysis prepared by DHS and reviewed by blueCONSULTING (Appendix V-B), the revenue to the County that would continue irrespective of the closing of RLANRC is \$35.7 million. The major component of this revenue (\$22 million) is SB 1255 revenue, which is allocated to RLANRC from a fixed sum negotiated by the County and CMAC, and which is allocated to County providers "at the sole discretion" of the County.

VI. OBJECTIVE 6

Objective 6: *Determine whether any similar hospitals exist and the extent to which they are subsidized. Determine significant differences in their operations from RLANRC to identify areas the County can pursue to obtain self-sufficiency.*

Summary Analysis

There are numerous rehabilitation facilities around the nation, a number of which offer services commensurate with those provided at RLANRC. However, there do not appear to be any rehabilitation facilities of the caliber of RLANRC¹² that are similar in terms of governance and low-income utilization levels. There are other public hospitals with rehabilitation units, such as Santa Clara Valley Medical Center (SCVMC) in Northern California, and the Susan Smith McKinney Nursing and Rehabilitation Center in Brooklyn, New York (part of the Health and Hospitals Corporation). However, neither of these facilities is directly comparable to RLANRC (Santa Clara's rehabilitation beds are in a unit of the general acute hospital, and the McKinney facility is more similar to a skilled nursing/sub-acute facility).

Accordingly, RLANRC is a unique facility offering a high level of rehabilitation services to a multicultural patient base, while operating as a public hospital. However, even despite RLANRC's unique status as a public hospital, there are a few insights into self-sufficiency that can be drawn from comparisons with other "top tier"¹³ rehabilitation facilities around the country.

The nature of RLANRC as a public rehabilitation hospital, funded principally with local indigent care funds, Title XIX (Medicaid funds), Disproportionate Share Hospital (DSH) funds, and various other state-sponsored funding initiatives, makes it unique among its peers. This contrasts with private facilities which do not receive government subsidy. These circumstances also make it unlikely that RLANRC will ever achieve the ratio of publicly- versus privately-funded patients enjoyed by its counterparts, nor is it necessarily financially advantageous for them to do so, given the financing mechanisms used in Los Angeles County for public hospitals.

RLANRC may be able to reduce costs by sharing services with an acute care facility, as do some of its top tier counterparts. Additionally, as a Quasi-Governmental Organization, RLANRC might benefit from more successful contracting with private insurance carriers and managed care plans.

Methodology

To accomplish Objective 6, blueCONSULTING compared RLANRC operations and statistics with other rehabilitation facilities using three separate comparative analyses:

- A comparison of RLANRC with a selected list of the ten most comparable rehabilitation hospitals from the *US World & News Report* identifying "best in class" facilities.

¹² Based on the *US News & World Report* survey.

¹³ As identified in the *US News & World Report* survey.

- A review of publicly available Cost Report data.

Findings and Conclusions

- Comparison with other top tier rehabilitation hospitals. Each year, *US News & World Report* ranks a variety of hospitals/medical facilities. Rehabilitation hospitals are ranked based on the reputation of each facility. In the most recent survey, RLANRC ranked ninth nationally.
- blueCONSULTING has developed a summary table with the characteristics of ten rehabilitation hospitals that are nationally recognized (see Exhibit VI-1). All but two of these facilities ranked in the top overall ten of the *US News & World Report* list published in 2002. The other two facilities, Spaulding Rehabilitation Hospital in Boston and National Rehabilitation Hospital in Washington, DC were ranked numbers 11 and 12 respectively.
- The most striking difference between the other top tier facilities ranked by *US News & World Report* and RLANRC is their status as private facilities. None of the top tier facilities are public facilities except RLANRC. Most of the facilities included in the summary chart are freestanding hospitals although two are units within acute care hospitals. All have some type of academic affiliation for one or more of their programs.
- The facilities have many similar programs, with all of the ten listed providing rehabilitation of Spinal Cord Injury (SCI) and Traumatic Brain Injury (TBI) patients. The size of the facilities varies, with RLANRC being among the largest. Based on the available information it also appears that RLANRC’s overall staffing per bed is in line with those of these other facilities.
- However, two additional areas of differences are noted.
 - First, most of these facilities have many managed care and health insurance contracts/agreements, making them available to a wide array of privately insured patients. RLANRC has substantially fewer contracts than others. There are differences of opinion on why Rancho has fewer contracts nor is there a general consensus on whether or not such contracting would be financially advantageous.
 - Second, RLANRC’s Medicaid caseload is significantly higher than any of the other facilities (where this information was known). While information on the number of indigent, unreimbursed patients served by these facilities was not available, it seems unlikely that it would approach RLANRC’s caseload given the private nature of these facilities and their low Medicaid utilization rates.
- Based on available cost report data¹⁴, the operating expense per day for five of the facilities was reported as follows:

Rehabilitation Institute of Chicago	\$1,978.00
Institute for Rehabilitation and Research	\$1,716.00
Craig Hospital	\$1,536.00
National Rehabilitation Hospital	\$1,296.00
Spaulding Rehabilitation Hospital	\$1,184.00

¹⁴ As reported to American Hospital Directory: Financial Statistics.

- RLANRC's cost per day according to the model prepared for FY 00/01 was \$1,879.00.

Self-Sufficiency

- Self-sufficiency in an environment characterized by relatively restricted reimbursement levels (high Medicaid and indigent care caseloads) is inevitably tied to an organization's ability to tightly manage major cost components within the facility, such as labor and capital improvements. Both will be difficult for RLANRC in the coming years given the seismic upgrades required to maintain a facility of its current size and the costs associated with the County's labor structure.
- To achieve self-sufficiency, RLANRC should consider the following success factors:
 - Maintain a high occupancy rate and high proportion of funded patients;
 - Reduce labor costs via an alternate governance structure which will permit it to move away from the County civil service pay structure, benefit costs and work rules;
 - Avoid building a new facility unless RLANRC can demonstrate that it can fill the new beds with funded patients and it can raise at least some of the capital through philanthropic avenues (thereby reducing the overall debt service);
 - Occupy a position as a specialty niche provider for patients requiring acute rehabilitation or after-care resulting from exacerbations of those conditions (paralysis, TBI, etc) and avoid replicating the services provided by general acute hospitals with which RLANRC is not prepared to compete for business with most payers.

Given these success factors, obtaining self-sufficiency as an independent freestanding facility will not be easy even under an alternative governance structure, but is almost impossible under the existing departmental relationship within the County.

Exhibit VI-I: Characteristics of Comparable Facilities

Facility	Public/ Private	Affiliations	Freestanding/ Satellite or Distinct Part	Key Services	# of Beds	Managed Care/ Ins. Contracts	# of Employees per Bed	Percent Medicaid
Rehabilitation Institute of Chicago (Chicago, IL)	Private	Northwestern University School of Medicine	Freestanding with multiple locations	SCI, CP, TBI, MS, Stroke, Transplant, Amputation	135	Many	598	17.9%
National Rehabilitation Hospital (D.C.)	Private	MedStar Health System Georgetown University	Freestanding with multiple locations	SCI, Stroke, TBI, Amputation, Pediatrics (OP)	128	Many	48	7.5%
Institute for Rehabilitation and Research (TIRR) (Houston, TX)	Private	University of Texas	Freestanding with multiple locations	SCI, TBI, Amputation, Pediatrics	70	Many	447	2.8%
University of Washington – Dept of Rehabilitation Medicine (Seattle, WA)	Private	University of Washington Harborview Medical Center	Unit within the Medical Center	TBI, SCI, MS	30	Many	N/A	43.2
Mayo Clinic (Rochester, MN)	Private	Mayo System/St. Mary’s Hospital	Unit within St. Mary’s Hospital	Amputation, TBI, SCI, Stroke, CP, MS, MD	48	Many	N/A	3.98%
Kessler Adventist Rehabilitation Hospital (MD and NJ)	Private	Adventist Health System Shady Grove Hospital (MD) University of Medicine and Dentistry of NJ	2 Freestanding Hospitals with multiple locations	TBI, SCI, MS, MD, Amputation	55 in MD 80 in NJ	Unknown	N/A	N/A
Craig Hospital (Englewood, CO)	Private	University of Colorado	Freestanding	SCI, TBI	76	Many	5.61	8.5%
Rusk Institute of Rehabilitation Medicine (New York City, NY)	Private	NYU Medical Center Tisch Hospital	Freestanding, adjacent to Tisch Hospital	Amputation, SCI, Traumatic injuries, TBI, MS	174	Many	N/A	N/A
Spaulding Rehabilitation Hospital (Boston, MA)	Private	Mass General Harvard Medical School	Freestanding with multiple locations	Amputation, SCI, Stroke, TBI	259	Unknown	3.94	0.0%
Rancho Los Amigos National Rehabilitation Center (Los Angeles, CA)	Public	Los Angeles County Public Hospital System	Freestanding	TBI, SCI, Liver, Ortho-Diabetes, Pediatrics, Urology, Stroke, Gerontology, Surgery, Medicine	207	Few	4.94	52.3%

